DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 98 — 17 (MA)

2. STATE: New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 20, 1998

5. TYPE OF PLAN MATERIAL *(Check One)*:

☒ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 U.S.C. 1396a(a)(13), (10); 1396r-4(a)

7. FEDERAL BUDGET IMPACT:
a. FFY 1998 $ -0-
b. FFY 1999 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment #/ 4.19-A; pages III-3 through III-10

**SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
new

10. SUBJECT OF AMENDMENT:
Out-of-state Hospital Appeals

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Exempt pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Michele M. Ouml

14. TITLE:
Commissioner

15. DATE SUBMITTED:

16. RETURN TO:

Division of Medical Assistance
and Health Services
P.O. Box 712
Trenton, New Jersey 08625-0712

FOR REGIONAL OFFICE USE

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 20, 1998

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME:
Sue Kelly

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

As per State Letter of 5/17/01, Attachment 4.19A, page III-5 is being eliminated. Attachment 4.19A, pages III-3 and III-4 have been revised from original submission.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Out-of-State Hospitals

2. Basis of payment and appeal procedure; out-of-state hospital services

(a) The following rate appeal procedure shall be followed for a rate appeal filed by an out-of-state hospital that participates in the Medicaid program of the state in which it is located. This procedure does not apply to out-of-State hospitals that are not participating in their state's Medicaid program:

1. If an out-of-state hospital wishes to file an appeal concerning issues related to the rate of reimbursement, the appeal shall be filed by the hospital, in writing, to the following address within 20 calendar days after the filing of a rate appeal by the hospital to the State Medicaid agency in the state in which the hospital is located.

2. The following limitations shall apply to the rate appeal procedure in (a)1 above.

   i. The hospital shall submit with its rate appeal to the Division all appropriate documentation demonstrating that an appeal was filed with the State Medicaid agency in the state in which the hospital is located and the date that the appeal was filed.

   ii. If the hospital did not file a timely appeal in the state in which it is located, the payment made by the New Jersey Title XIX program shall be considered the final payment.

TN 98-27 Approval Date JUN 06 2001
Supersedes TN New Effective Date 7/20/98